STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125024	A. Building B. Wing	12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nuuanu Hale	2900 Pali Highway Honolulu, HI 96817

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on record review and interviews, the facility failed to ensure a resident's right to receive a written notice before the resident's roommate in the facility is changed for one of three residents (Resident (R)9) sampled. R9 and the resident's representative did not receive a written notification prior to moving two roommates into the resident's room. The deficient practice could potentially affect the physical and emotional well-being of all residents involved. Findings include: Reviewed the ACTS intake #9560 received on 07/18/2022 via email to the Office of Healthcare Assurance (OHCA). R9's Family Member (FM)1 reported that she did not receive written notice, including the reason for the changes before two new roommates were moved into her mother's room on June 9, 2022. FM1 filed a grievance with the facility on July 8, 2022, about the incident. The facility responded to her grievance in a letter dated July 11, 2022 that included responses to some of FM1's questions (regarding the addition of 2 new roommate's to R9's room) she had concerning the move. FM1 was not satisfied with the facilities response. On 12/19/22 at 09;00 AM, received Telephone call from FM1 who reported R9 is Covid positive for the second time, and is in isolation with three new residents that were moved into her room. FM1 stated that she did not receive a written notice about the roommate changes and is concerned about her mother since she has dementia and is in isolation due to having COVID 19 with new roommates. Adding that this was the second time this happened and that her mother requires sharing a room with others who are compatible with her due to her sensitive needs. On 12/20/22 at 11:45 AM, observed R9 in her room. Noted three curtains were pulled around the roommate's beds two, three and four. R9 was sitting in a wheelchair next to her bed with her head down and appeared to be staring at the floor. On 12/20/22 at 1:00 PM, a review of R9's Electronic Medical Record (EMR) documented R9 is a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Dementia. No written notice or documentation regarding the addition of two roommates to R9's room when the resident was COVID positive was found to indicate the resident or the resident's representative was notified before the roommate changes occurred. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/22 at 1:00 PM an interview was conducted with the Administrator, Director of Nursing (DON), and Social Services Director (SSD). Surveyor inquired if the two other residents who were transferred into R9's room received written notice about the room change and what is the facility procedure to ensure resident's and their representatives are notified regarding room changes? SSD explained that the resident and representative are verbally notified. The DON stated that she spoke to R9's daughter in length about this, at the time she was concerned about the other resident's husband when he visited in the room. The Administrator, DON, and SSD could not provide documentation that a written notification was sent to R9 or FM1 regarding the addition of two roommates. On 12/22/22 at 09:00 AM, reviewed the Resident Handbook dated 07/2021(page 15) Room Assignments. Careful consideration is given to a resident's needs and desires when room assignments are made .Unless there is an emergency, the resident, family, or personal representative are informed before any room change is made. The policy did not state the resident or representative will be provided written notification before the move.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on interviews and record reviews, the facility failed to ensure a written transfer/discharge notice was provide to a resident Resident (R)3 and the resident's representative (Famliy Member (FM)1) prior to discharge. FM1 received a discharge notice via email the day after R3 had been discharged . Additionally, FM1 did not know the reason R3 was discharged , effective date of the discharge, or where R3 was discharged to due to the physician's lack of documentation. As a result of this deficiency, the resident's right to receive services and proper notification prior to discharge were violated. Findings include: Conducted a review of R3's Electronic Medical Record (EMR) on 12/20/22 at 11:30 AM that documented R3 is a [AGE] year old female who had a hip surgery at the Hospital (H)1 and was transferred to the facility on [DATE] to receive skilled nursing services. R3 has diagnosis that includes a history of mental (bipolar disorder) and behavioral disorders (receives antipsychotic medication) and has had recent surgery that required skilled nursing care. On 12/06/22, the resident was sent to the emergency department for severe agitation. The EMR did not have documentation of a written discharge summary or that a written discharge summary was sent to the resident or FM1. Further review of R3's EMR confirmed there was no documentation by the physician of the reason R3 was discharged or where the resident had been discharged to. On 12/20/22 at 11:30 AM, reviewed the electronic medical record (EMR). R3 is a [AGE] year old female who had a hip surgery at the Hospital (H)1 and was transferred to the facility on [DATE] to receive skilled nursing services. Active diagnoses included. Personal history of mental and behavioral disorders. Recent surgery requiring active skilled nursing facility (SNF) Care. History of bipolar disorders and is on medications (Antipsychotics). On 12/06/22 the resident was sent to the Emergency Department (ED) for severe agitation. No discharge notice found to indicate the resident or representative were notified of the discharge prior to the discharge to the H3. No documentation was found to indicate the physician documented in the EMR the reason why the resident was being discharged and where the resident was discharged to. During an interview with the Administrator on 12/22/22 at 10:51 PM, the Administrator explained R3 was in a violent state, attempted to strangle Licensed Nurse (LN)5 with a stethoscope, then 911 was called. R3 was discharged to H2 for a psychiatric evaluation and the ambulance took R3 directly to H2. The Administrator stated that the facilty found out later that R3 was not taken to H2 but to H3, and psychiatric services are not provided there. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed the facility's Notice of Discharge/Transfer form confirmed the dated on R3's form was 12/07/22, which was the day after R3 was discharged . The facility documented on the form as This notice is to inform you .discharge/transfer is necessary due to the following reason (s) .The health and safety of individuals in the facility are or would otherwise be endangered; Resident was discharged d/t unsafe to self/others. Discharge/Transfer to H3 discharge date : 12/06/22. Note written by the SSD called/ spoke with FM1 via phone and explained to her about the facility notice of discharge/ transfer and that SSD will email her a copy. 12/09/22: FM1 declined to sign. The form did not include documentation by the physician that indicated R3's discharge diagnosis, documentation to substantiate R3's discharge, or a written notification was provided to FM1 prior to R3's discharge. On 12/22/22 at 12:00 PM, reviewed the discharge or transfer for hospitalized residents Policy and Procedure. Page 1, paragraph 2. On all discharges/transfers: a. Discharge summary must be completed by physician with discharge diagnosis .Facility will have documentation in the resident's record to substantiate a transfer or discharge .3. Resident or resident representative has been verbally informed of discharge and provided with written notice in language that they are able to understand. 4. Charge Nurse or licensed staff will document in residents record that the above actions have been completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on interview and record review, the facility failed to allow one of three (resident (R)3) residents sampled, to return to the facility from the Emergency Department (ED) at the Hospital (H)3 on 12/06/22. After R3 was stabilized by the ED, the facility refused to take her back to continue with her skilled nursing services. The facility failed to develop and follow a policy that would allow the resident to return to the facility after discharge. The deficient practice affected the residents physical and emotional well-being and potentially impacted her mental health status because of the lag in services from being discharged and not allowed to return to the facility. Findings include: (Cross reference F684 Quality of Care) On 12/19/22 at 3:00 PM, reviewed an event report dated 12/07/22 at 02:05 PM that was sent to the Office of Healthcare Assurance (OHCA) from the acute care hospital (H)3. Patient was received to the ED on 12/06/22 via ambulance where she was seen and treated for agitation. The ED called the facility to report that R3 was ready to return to the facility but was told by the Licensed Nurse (LN)5 she will not be accepted back to the facility due to her aggressive behavior. On 12/07/22 (a day after) the ED manager (EDM) contacted the facility Director of Nursing (DON), explained the situation that the facility needs to take their resident back, especially since H3 can't provide a psychiatric evaluation. The EDM was told by the facility that the bed was given away and R3 will not be able to return. On 12/08/22 (insert time) the Registered Nurse Case Manager (RNCM) spoke with the Admissions Director (AD), from the facility. RNCM told the AD that R3 needs to be returned to the facility. The AD told her that R3 would not be able to return unless she receives a Psychiatric evaluation. On 12/20/22 at 10:00 AM, reviewed the electronic medical record (EMR) for R3. R3 is a [AGE] year-old female who was transferred from H1 to the facility on [DATE] for rehabilitative services following a hip surgery. On 12/06/22 when R3 became combative and aggressive 911 was called and she was discharged from the facility. She stayed in the emergency department for 3 days before being admitted to HOSP3. Nursing notes dated 12/06/2022 at 17:14 due to (d/t) no improvement in aggressive behaviors, advised by unit Supervisor to request patient be sent out for psych eval. 911 operator sent police officers to unit to respond to combative behavior. Officers able to calm patient to the point of no physical behavior Ambulance arrived at 1515 along with 1 officer. Transported to H3. Reviewed Physician order dated 12/06/22 at 1430, Discharge resident to H2 for psych admission. Nursing notes dated 12/07/2022 at 06:12 PM reviewed. Resident arrived at facility via ambulance and was met in the parking lot by me, DON, and Admissions coordinator. Resident was inside the ambulance, when the EMT's shut the doors, R3 was heard to be screaming from inside ambulance .to our knowledge a psych eval was never done because resident ended up at H3, which does not have an in-house psych team. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator, DON, and Social Services Director (SSD) on 12/22/22 at 10:51 AM. Asked why the resident was not received back to the facility after receiving treatment to stabilize her agitation. The Administrator explained that we discharged the resident to H2 for a psychiatric evaluation, but they didn't take her there, and instead took her to H3. The next day when the ambulance brought her back, we told them that we can't take R3 back without having a psychiatric evaluation. Surveyor asked if the facility had reviewed her medical history from H1 who transferred her and if any concerns were identified about R3's behavior, prior to being admitted for skilled nursing at the facility. Both the DON and SSD replied that H1 didn't inform us there were any problems with her behavior and said R3 was stable. On 12/22/22 at 11:00 AM, reviewed the Facility Policy and Procedure for Discharge or transfer for hospitalized residents. The policy did not address permitting residents to return to the facility after they are hospitalized who require the services provided by the facility and are eligible for MEDICARE skilled nursing services.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38870 Based on interviews and record review, the facility failed to ensure the accurate assessment, upon admission, for existing behavioral disorders that may indicate a psychiatric condition for one of three (Resident (R)3) residents sampled. R3 did not receive adequate treatment to address the resident's severe psychological needs. R3 was transferred to the Emergency Department (ED) after the resident's behavior escalated to physical and verbal aggression toward residents and staff. R3 was transferred between the facility and the Hospital (H)3 twice by ambulance, then waited in the ED for three days before receiving services. R3 did not receive skilled nursing services or a psychiatric evaluation while in the ED. Findings include: (Cross Reference to F623, Notice requirements before discharge/transfer, and F626, Permitting residents to return to the facility). On 12/20/22 at 10:00 AM, reviewed R3's Electronic Medical Record (EMR). R3's admission Minimum Data Set (MDS) documented R3's Brief Interview for Mental Status (BIMS) score was 0, indicating the resident's cognition was not measurable. R3's mood interview was 5, which indicates medium on the depression scale. R3 scored a 0 on the behavior interview, which indicates she didn't express any behavioral problems. Her active diagnoses included personal history of other mental and behavioral disorders and a history of falling, recent surgery requiring active skilled nursing facility (SNF) Care, and medication section indicated R3was taking antipsychotic's 5 times in the week. Baseline Care Plan dated 12/02/2022 reviewed. Cognitive: Alert and Oriented: x4. Behavior/ Mood: None. Pain: checked has pain or discomfort or potential location: Head, Hip (3). Preferences/ Strengths: Checked cognition/abilities to make own decisions, able to communicate needs. Comprehensive Care plan dated 12/05/22 reviewed; Behavioral symptoms, R3 exhibits verbally abusive behavioral symptoms. Target date 12/22/2022 (long term goal) Resident will not threaten, scream, or curse at other residents. Administer medications. Monitor and record effectiveness. Reviewed medication administration history dated 12/01/2022 to 12/06/2022. R3 takes the following routine antipsychotic medications. Risperidone 0.5 milligram (mg) tablet twice a day for a diagnosis (DX) of a personal history of other mental and behavioral disorders. Seroquel tablet; 50 mg; tab at bedtime. Crush and Administer 1 tab by mouth daily at bedtime for Bipolar. Reviewed orders: Monitor for angry outbursts for mood stabilizers drug use every shift day, evening, night (NOC) start 12/01/2022 to 12/06/2022. Psych Consult continuous as needed (PRN) start 12/01/2022 to 12/06/2022. Reviewed progress notes dated 12/01/22 to 12/06/22. No documentation found to indicate that R3's behavior was being monitored every shift of receiving as needed medication and no reference for a referral for psych consult was noted. No Pre-admission Screening and Resident Review (PASSR) level 1and 2 screening results found in the record. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/21/22 at 1:00 PM, telephone call to interview the registered nurse case manager (RNCM)5 at H3 and if R3 was there. RNCM5 confirmed R3 was in H3. Rehab services were started for R3 on 12/16/22 and that she is getting physical therapy (PT), and Occupational Therapy (OT). The facility said they wanted a psyche evaluation prior to receiving the resident back to their facility and we would have gotten one, but she wasn't appropriate since she already had one at the previous hospital (H1) where she had her surgery, and the facility should have consulted with H1 to ensure she received the psychological evaluation as this hospital does not have Psychiatric services. R3 was sitting in the ED from 12/06/22 to 12/09/22. On 12/22/22 at 11:00 AM, reviewed the Discharge summary from H1 dated 12/01/22 at 09:29 AM. Admitting diagnosis included Right hip fracture, Hypertension, Dementia Unspecified, Fall, History of Bipolar Disorder, (Personal history of other mental and behavioral disorders). R3 admitted for right Hip fracture, She did have some delirium and some issues with her history of bipolar. This was treated by Psychiatry. She will be on Risperdal and Seroquel (anti-psychotic medication used to treat behavior disorders). Reviewed the Baseline Care Plan dated 12/02/2022, PASSR box was not checked that it was reviewed and accurate. During an interview with the Administrator, Director of Nursing (DON) and Social Services Director (SSD) on 12/22/22 at 12:51 PM. Surveyor asked if the facility had called the H2 prior to sending R3 out for a psych eval to ensure services were available. The administrator replied that there was no communication between the facility and the hospital. The resident left by ambulance and was not taken to the intended location at H2, instead she went to H3. Surveyor asked if a screening was done prior to admission and if the facility had reviewed R3's medical history or had a conversation with staff at the transferring hospital as part of the assessment and to find out if any concerns were identified about R3's behavior prior to being admitted for skilled nursing at the facility. Both the DON and SSD replied that the Nurse Manager wasn't informed that there were any problems with her behavior. On 12/22/22 at 12:00 PM, reviewed the Admission Policy revised date 09/17/21 Pg. 2. 4. The following information is required at the time of admission. e. (PSSR) Level I/Level II evaluation. and procedure.